Stressors, moderators and stress outcomes: findings from the All-Wales Community Mental Health Nurse Study

D. EDWARDS[1] MPhil BSc(Hons), P. BURNARD[2] PhD MSc RMN RGN RNT DipN CertEd, D. COYLE[3] MEd RMN RNLD CertEd(FE), A. FOTHERGILL[3] PhD BSc(Hons) PGCE RMN RGN & B. HANNIGAN[3] MA BA(Hons) RMN RGN DPSN(CPN)

[1]*Lead Researcher,* [2]*Professor and Vice Dean and* [3]*Lecturer, School of Nursing & Midwifery Studies, University of Wales College of Medicine, Heath Park, Cardiff, CF14 4XN, Wales, UK*

Correspondence:
D. Edwards
School of Nursing and Midwifery Studies
University of Wales College of Medicine
Heath Park
Cardiff
CF14 4XN
Wales
UK

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The All-Wales Community Mental Health Nurse Stress Study was the largest study undertaken in the UK to date to investigate stress, burnout and coping amongst the CMHN workforce. The aim of the study was to examine the variety, frequency and severity of stressors, to describe coping strategies used to reduce work-based stress, and to determine stress outcomes. Questionnaires were sent out to 614 CMHNs from ten NHS Trusts throughout Wales. The response rate was 49% (n = 301). The measures used included the Maslach Human Services Survey, the CPN Stress Questionnaire, the Psychnurse Methods of Coping Questionnaire, the Rosenberg Self-Esteem Scale and the General Health Questionnaire GHQ-12. Community mental health nurses indicated that trying to maintain a good quality service in the midst of long waiting lists, poor resources, and having too many interruptions while trying to work in the office were particularly stressful items. The coping strategies that CMHNs utilized the most were having a stable home life and looking forward to going home at the end of the day, having outside interests and hobbies and talking to people that they got on well with. Forty per cent of CMHNs tended to view themselves negatively, feeling that others did not hold much respect for them. The GHQ-12 measure indicated that 35% of CMHNs had crossed a threshold of psychiatric caseness. Measured against a normative sample of mental health workers, 51% of CMHNs were experiencing high levels of long-term emotional exhaustion. Twenty-four per cent were suffering from high levels of depersonalization burnout and were not relating well to clients, whilst 14% were experiencing severe long-term feelings of lack of personal accomplishment. The results from the study provided us with a picture of stress and coping in CMHNs in Wales. Addressing these factors may help to reduce levels of experienced stress and burnout.

Keywords: burnout, community mental health nurses, coping strategies, occupational stress

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Introduction

In the mental health field, care is increasingly being provided in community settings involving workers representing a range of agencies and professions. In 1996, in the most recent quinquennial community mental health nursing survey, the total community mental health nursing workforce in England and Wales was estimated at just

under 7000 (Brooker & White 1997). Community mental health nurses (CMHNs) play a key role in providing and co-ordinating a variety of services to people experiencing mental health problems, including those suffering from severe and enduring mental illness, such as schizophrenia.

In recent years there has been much concern over the job-related satisfactions and difficulties of mental health nurses working in the community setting (Kipping & Hickey 1998). Increasing workloads, increasing administration and lack of resources have been indicated as sources of increasing stress and burnout for health professionals working as part of community mental health teams (Edwards *et al.* 2000). It has been suggested that this is particularly true for CMHNs (Brown *et al.* 1994). There is a growing body of evidence that indicates that many CMHNs experience stress and burnout (For example, Parahoo 1991, Schafer 1992, Carson *et al.* 1995, Fagin *et al.* 1995, McLeod 1997, Parry-Jones *et al.* 1998, Snelgrove 1998, Drake & Brumblecombe 1999). The consequences of stress and burnout in the workplace impact both on the individual and the organization. This affects not only the level of performance and success of interventions of mental health workers, but also job satisfaction and ultimately their own mental and physical health (Carson & Fagin 1996). From the literature, poor quality work, taking longer over tasks, and making more errors are some of the behavioural signs ascribed to stress, together with increased smoking, increased alcohol consumption and absenteeism. Other signs are cognitive changes, especially with regard to poor memory and concentration and impaired decision-making skills (Cooper 1984, Duckworth 1986).

Carson *et al.* (1997) have reported that studies which attempt to identify the specific occupational stressors confronting mental health nurses should also try to locate these stressors within an empirically derived, field-tested model of the stress process.

Duquette and colleagues, in a three-tier model of burnout, suggest that burnout is the end result of organizational stressors not adequately buffered by the key moderators of hardiness, social support and coping skills (Duquette *et al.* 1994).

Carson & Kuipers (1998) have proposed a similar model of the stress process, which incorporates the idea of stressors, moderators, and stress outcomes. Stressors are seen as arising from three main sources: those relating to one's occupation, major life events and hassles, and uplifts. The critical factor in the model the mediating or buffering factors which individuals can call upon to help them. These stressors will only lead to negative stress outcomes if the individual has insufficient resources to manage them. Carson & Kuipers (1998) propose a greater number of factors at this level than Duquette *et al.* (1994), and have further added self-esteem, mastery, personal control, emotional stability and physiological release mechanisms to the model. The final factor in the model is stress outcomes. Those staff with poor stress outcomes will experience psychological ill-health, low job satisfaction, and burnout (Fagin *et al.* 1996).

Whilst there are similarities in the organization and focus of mental health services in England and Wales, differences also exist. Key documents produced by the Welsh Office emphasize the community focus of mental health care (Welsh Office 1996). There has, however, been no formal adoption of the care programme approach (CPA) in Wales, while in England it is now the cornerstone of mental health care (DoH 1995).

The environment within which Welsh CMHNs work is therefore distinct from the environment within which their English counterparts work. In England, previous research, beginning with the Claybury stress study, has established that many CMHNs experience considerable stress (Carson *et al.* 1995, Fagin *et al.* 1995, Leary *et al.* 1995). The only survey conducted in Wales to date is the Mental Health Care survey, which indicated that mental health nurses in Wales had higher levels of stress than nurses surveyed in England (excluding London) (Carson *et al.* 1997). However, only 24% of CMHNs responded to the questionnaire, limiting generalizability of these findings.

The overall aim of the all-Wales stress study was to replicate the work of the Claybury stress survey, using the total population of CMHNs working in Wales. The specific objectives were: to examine the variety, frequency, and severity of stressors amongst CMHNs working in Wales; to describe coping strategies used by CMHNs to reduce work based stress; and to determine stress outcomes. The All-Wales Community Mental Health Nurse Stress Study was the largest single UK survey undertaken to date that used a number of validated instruments to survey the total CMHN workforce in Wales in relation to stress, burnout and coping. This paper will present an overview of all the findings from the all-Wales stress study. More detailed discussion on each of the scales and the demographic questionnaire will be reported elsewhere.

Method

Three hundred and one qualified CMHNs from ten NHS Trusts in Wales returned questionnaires. This represented a 49% response rate. The following research measurements were included in a questionnaire booklet:

Welsh CMHN Stress Study Demographic Questionnaire

This was a 19-item measure covering issues such as caseload size, client group, and team location. It also included

Table 1a
Characteristics of the sample

Variable	*n*[1]	Mean	SD	Minimum	Maximum
Caseload size	293	37.9	16.7	3	110
Age	291	40.4	7.2	23	63
Hours per week	296	36.4	4.5	18.35	50
Number of months in current position	292	78.5	67.5	1	300
Number of years in field	293	16.9	7.6	1	40
Days off sick in past year	299	9	17.2	0	120

[1] *n* refers to the number of respondents supplying the relevant information.

open-ended questions on stress and coping. This was devised especially for the study.

Maslach Human Services Demographic Data Sheet

This is a 15-item measure covering issues such as gender, age, martial status, and experience, and was used in conjunction with the Maslach Burnout Inventory (Maslach et al. 1996).

CMHN Stress Questionnaire (Revised) This is a 48-item questionnaire which subjects were asked to score on a 5-point scale, from 0, 'this item causes me no stress', to 4, 'this causes me extreme stress' (Brown *et al.* 1995).

PsychNurse Methods of Coping Questionnaire

This is a 35-item questionnaire on which subjects were asked to score on a 5-point scale the extent to which strategies are used to deal with stress, from 1, 'never', to 5, 'all the time'. This coping indicator provides information on six types of coping strategy. These are diverting one's attention away from work, self-regulation and self-attitude, social support at work, positive attitude towards one's role at work, and emotional comfort (McElfatrick *et al*. 2000).

Rosenberg Self-Esteem Scale

The modified version of Rosenberg's (1965) scale was used (Wycherley 1987). Scores vary between 10 and 40, and low scores indicate better self-esteem.

General Health Questionnaire GHQ-12

The GHQ-12 is a scale that measures psychological distress. Two scores are obtained. These are firstly, the total GHQ score, which ranges from 0 to 12 when using a binary coding method (Goldberg & Williams 1988), and secondly, a 'caseness' score. A rating of caseness is made on scores of 2 or more on this version.

Maslach Burnout Inventory

This is a human services burnout measure comprising three subscales, for which two types of scores can be obtained, a total score for each subscale and a categorical rating as high, moderate or low burnout. The subscales are emotional exhaustion, depersonalization, and personal accomplishment (Maslach *et al*. 1996).

Results

Not all the respondents answered all the items on each measure. Where this was the case the subjects were excluded from the analysis for that particular measure. The characteristics of the sample as determined by the demographic questionnaire are presented in Tables 1a and 1b.

The majority of CMHNs were grades E (27%), F (13%) and G (49%). Further investigation of client group revealed that of those who worked with a specific client group, 66 (34%) worked with the elderly, and 94 (49%) worked with severe mental illness and rehabilitation. The findings from the individual scales are presented in the next section.

CPN Stress Questionnaire (Revised)

The average CPN Stress score was 65.1 (SD 28.8, range 13–144). The results from all 48 items on the completed CPN Stress Questionnaire were analysed by ranking the overall average value of the Likert (0–4) score for each item. Brown & Leary (1995) employed this method of ranking. Rankings of the ten most stressful and least stressful item are presented in Tables 2 and 3, respectively.

Rosenberg Self-Esteem Questionnaire

The average score for CMHNs was 18.8 (SD 4.7, range 10–33). The interpretation of the modified Rosenberg scores is recorded in Table 4.

Coping strategies

Ninety-three per cent of CMHNs felt that they could discuss their work-related problems with their work colleagues, and this was a means of alleviating work-related stress. In reply to the question 'how would you describe

Table 1b
Characteristics of the sample

Variable	*n*	%
Position		
Staff member	223	76
Supervisor/Manager	72	24
Smoking		
Yes	95	68
No	205	32
Alcohol		
Yes	252	15
No	46	84
Geographical location		
Urban	150	50
Rural	134	45
Mixed	13	4
Specialist course		
Yes	121	41
No	177	59
Job security		
Yes	237	80
No	59	20
Gender		
Male	112	38
Female	185	62
Marital status		
Single	27	9
Married/Living with partner	231	78
Divorced/widowed/separated	32	11
Client group		
Specific	187	62
Mixed	114	38

the attitude of your line manager toward you?', 86% of CMHNs considered that their line managers supported them. Table 5 gives the average scores for CMHNs on the five subscales of the coping strategies measure.

The results from all 35 items on the completed Psychnurse Methods of Coping Questionnaire were analysed by ranking the overall average value of the Likert (1–5) score for each item. Rankings of the ten most and least used coping methods are presented in Tables 6 and 7, respectively.

General Health Questionnaire GHQ-12

The average GHQ-12 score was 2.6 (SD 3.4, range 0–12). Thirty-five per cent of the CMHNs in the sample crossed the threshold of 'psychiatric caseness' on the GHQ, scoring 2 or above.

The mean scores for this measure were significantly higher for those who smoked, those who felt that they did not have job security, and those who were divorced, widowed or separated. These results are presented in Table 8.

There was a significant positive correlation between GHQ-12 scores and the MBI emotional exhaustion subscale ($r = 0.497$, $P < 0.01$), the MBI depersonalization

Table 2
Rankings from the CPN Stress Questionnaire: the ten most stressful items

Rank	Item	Mean stress score (range 0–4)
1	Not having facilities in the community that I can refer my clients on to	2.20
2	Trying to keep up good quality care in my work	2.02
3	Having too many interruptions when I am trying to work in the office	2.00
4	Knowing that there are likely to be long waiting lists before my clients can get access to services, e.g. to see a psychologist	1.94
5	Having to keep detailed records/notes on clients	1.89
6	Having to visit unsafe areas	1.79
7	Feeling that other people expect too much from me as a CPN	1.76
8	Not being informed of treatment affecting my client, e.g. changes in medication	1.73
9	Having to deal with suicidal clients on my own	1.73
10	Feeling that there is not sufficient hospital back-up	1.72

Table 3
Rankings from the CPN Stress Questionnaire: the ten least stressful items

Rank	Item	Mean stress score (range 0–4)
1	Not feeling that I can rely on the support of my CPN colleagues	0.50
2	Having to carry drugs around	0.63
3	Feeling that there is a communication problem with my colleagues	0.65
4	Having to receive supervision that I do not find helpful	0.70
5	Having to obtain a suitable caseload/experience for students	0.79
6	Having problems getting to some client's homes, e.g. having to go into big housing estates	0.79
7	Feeling that the management style within our department is inflexible	0.94
8	Having to drive a lot in the course of a week	0.96
9	Feeling that other people underestimate my skills as a CPN	0.99
10	Having to put up with interruptions when seeing clients at home	0.99

Table 4
Interpretation of Rosenberg Self-Esteem scores

Score	Interpretation	*n*	%
10–13	You see yourself very positively, as a competent and valuable person	49	16
14–16	You generally have a positive view of yourself	45	15
17–20	You have an average, fairly balanced view of yourself as having both good and bad points	86	29
21–25	You tend to be somewhat negative and self-critical	104	35
Above 25	You generally see yourself very negatively, as less valuable and competent than others	14	5

Table 5
Mean scores for coping strategies from the Psychnurse Method of Coping Questionnaire

Coping strategy	Mean	SD	Minimum	Maximum
Diverting one's attention away from work	35	5.7	16	70
Self-regulation and self-attitude	22	3.4	12	30
Emotional comfort	19	2.8	10	25
Social support at work	20	4.1	10	30
Positive attitude towards one's role at work	32	5.0	16	14
Psychnurse overall score	128	16.5	76	169

n = 299, as data was unavailable for two cases.

Table 6
The ten most-used coping items, as rated by the Psychnurse Coping Questionnaire

Rank	Item	Mean coping score (range 0–4)
1	Having a stable home life that is kept separate from my work life	4.35
2	Knowing that my life outside work is healthy, enjoyable and worthwhile	4.17
3	Talking to people I get on well with	4.15
4	Looking forward to going home at the end of each day	4.15
5	Having pastimes and hobbies outside of work	4.14
6	Being able to draw upon my own knowledge and experience when necessary	4.13
7	Discussing problems with colleagues as they arise at work	3.93
8	Having a steady partner to turn to	3.93
9	Detaching myself from work matters when necessary	3.88
10	Taking a mature view of the situation	3.84

Table 7
The ten least-used coping items, as rated by the Psychnurse Coping Questionnaire

Rank	Item	Mean coping score (range 0–4)
1	Having team supervision	2.81
2	Having confidential 'one-to-one' supervision	3.07
3	Reminding myself that others have placed their trust in me	3.19
4	Having a satisfying sex life	3.21
5	Having support from my line manager	3.28
6	Reminding myself that the work I do is being appreciated	3.30
7	Finding out how others have coped in the same situation	3.38
8	Having a good, positive atmosphere around me at work	3.49
9	Managing my time efficiently	3.53
10	Sleeping restfully	3.53

subscale ($r = 0.233$, $P < 0.01$) and the total Rosenberg Self-Esteem score ($r = 0.454$, $P < 0.01$).

There was a significant negative relationship between the GHQ-12 scores and the total Psychnurse Methods of Coping Questionnaire ($r = –0.315$, $P < 0.01$) and the personal accomplishment subscale ($r = –0.369$, $P < 0.01$).

Maslach Burnout Inventory

Two hundred and eighty-three CMHNs completed the 22-item Maslach Burnout Inventory (MBI). Respondents were asked to rate items such as 'I feel emotionally drained from my work' on a scale of 0, 'never', to 6, 'everyday'. From these frequencies, mean scores were obtained for each of

Table 8
Significant results of *t*-tests for the General Health Questionnaire and demographic variables

Variable	*n*	Mean	SD	*t*	d.f.	95% CL Lower	95% CL Upper	*P*
Marital status				2.21	256	0.15	2.62	0.028
Divorced/widowed/separated	32	3.8	3.3					
Married/with partner	226	2.4	3.7					
Job security				2.17	287	0.0098	2.05	0.031
No	57	3.5	3.7					
Yes	232	2.4	3.3					
Smoker				2.08	291	0.0047	1.70	0.039
Yes	92	3.2	3.6					
No	201	2.3	3.2					

Table 9
Data on the subscales of the Maslach Burnout Inventory

MBI subscale (range)	*n*	Mean	SD	Minimum	Maximum
Emotional exhaustion (0–78)	283	21.2	10.3	0	24
Depersonalization (0–96)	283	5.2	4.5	5	48
Personal accomplishment (0–84)	283	34.8	6.5	1	48

Table 10
Categorization of MBI scores

	Low burnout		Average burnout		High burnout	
MBI subscale	*n*	%	*n*	%	*n*	%
Emotional exhaustion (EE)	68	24	70	25	145	51
Depersonalization (DP)	162	57	51	18	70	25
Personal accomplishment (PA)	166	59	77	27	40	14

EE: Low (13, average 14–20, high ≥ 21); DP: low (4, average 5–7, high ≥ 8); PA: low ≥ 34, average 33–39, high (28).

the three subscales. For the emotional exhaustion and depersonalization subscales, high mean scores reflect high levels of burnout, whilst for the personal accomplishment subscale, low scores reflect high levels of burnout. Data relating to mean scores on these subscales of the MBI are presented in Table 9. These mean subscale scores were compared with normative scores for the corresponding subscales for the 'mental health' occupational subgroup contained within the current edition of the Maslach Burnout Inventory Manual (Maslach *et al.* 1996). On the basis of this comparison, respondents were allocated to a 'high burnout', 'average burnout' or 'low burnout' category for each of the three subscales. Data relating to the categorization of MBI scores into 'high', 'average' and 'low' for each of the three subscales are presented in Table 10.

Discussion

The stress model outlined by Carson & Kuipers (1998) underpinned this study. This model comprises three tiers: stressors, moderators and stress outcomes. The results of the CPN stress questionnaire indicate that CMHNs are experiencing high levels of stress. As well as indicating the severity of stress experienced, the responses from the CPN stress questionnaire can be utilized to determine the nature of particular stressors. This measure revealed that organizational factors, as opposed to negative patient characteristics, were major sources of stress for CMHNs in Wales, UK. Community mental health nurses indicated that trying to maintain a good quality service in the midst of long waiting lists and poor resources, and having too many interruptions while trying to work in the office, were particular stressful items. Parry-Jones *et al.* (1998), in a small study of social workers, community nurses and CMHNs in Wales, found that since the implementation of the NHS and Community Care Act 1990, levels of stress had increased, and levels of job satisfaction had decreased. The heart of the problem was revealed to be increased workload and administrative duties combined with reduced time for service-user and family contact. It is clear from the literature that CMHNs in Wales are not alone with these problems. These findings are similar to those found in the Claybury Study (Brown & Leary 1995), and in studies on forensic community mental health nurses (Coffey 1999), ward based psychiatric nurses (Cronin-Stubbs & Brophy

1985, Dawkins *et al*. 1995, Jones 1987), and general nurses (McGrath *et al*. 1989).

It appeared that CMHNs in the all-Wales stress study were frustrated because in their opinion patients were not receiving the best quality care, due to lack of facilities and long waiting lists. This is supported by the work of Kipping & Hickey (1998), who identified large caseloads as a factor that CMHNs felt inhibited care provision. This limited the time available for each individual patient.

The critical factor in the model is the mediating or buffering factors which individuals can call upon to help them. Potential stressors will only lead to negative stress outcomes if the individual has insufficient resources (coping strategies) to manage them. Carson & Kuipers (1998) proposed self-esteem to be an important moderating factor in their model. In the present study it was found that the CMHNs had healthy self-esteem. The average score from the Rosenberg Self-Esteem Scale indicated that, at the time of the study, the CMHNs had a fairly well balanced view of self, encompassing both good and bad points. This finding, however, is masked by the fact that 40% of the sample were experiencing low self-esteem, in that they tended to view themselves negatively, feeling that others did not hold much respect for them. This is a concerning finding and will be explored in more depth in a separate paper.

The rankings from the Psychnurse Stress Questionnaire on different methods of coping indicated that CMHNs favoured informal approaches to cope with work-based stress. Having a stable home life, looking forward to going home at the end of the day, having outside interests and hobbies, and talking to people that they got on well with were some of the top ranking items. Only a small number favoured supervision (group or one-to-one basis) or having support from their line manger. However, the Psychnurse instrument does not have the ability to distinguish between those who did not receive supervision and those who did not use it as a coping strategy. This issue will be addressed by further qualitative research, to be undertaken in the second phase of this study.

The study revealed that nurses appear to value the presence of their colleagues in terms of the support they derive from proximity, but that this proximity can, however, bring with it practical problems in day-to-day working. This is consistent with findings from previous studies (Coffey 1999).

The final factor in the model is stress outcomes, and individuals will experience either good or poor stress outcomes depending on the effectiveness of the moderating factors. The results from the GHQ-12 and the Maslach Burnout Inventory can be utilized to determine stress outcomes.

Just over one in three CMHNs have crossed the threshold of 'psychiatric caseness'. It is difficult to make comparisons with other studies on this measure because of the range of different scoring methods used. This study adopted the simplest approach to scoring, as described in the GHQ-12 handbook, in order to avoid 'middle users'. A number of studies have utilized the simple Likert scoring method with cut points of 3–4 (Fielding & Weaver 1994) and 4–5 (Snelgrove 1998, Prosser *et al*. 1996). The mean scores for these studies ranged from 9.7 to 11.8 (possible range 0–24). However, for studies that have utilized the GHQ-28 scoring method (Schafer 1992, Fagin *et al*. 1995, Oliver & Kuipers 1996, McLeod 1997, Drake & Brumblecombe 1999), 20–44% of CMHNs were identified as 'cases', i.e. describing symptoms which would be classified as mild psychiatric morbidity. McGrath *et al*. (1989), in a sample of nurses in Northern Ireland found that the GHQ-12 and the GHQ-28 revealed similar findings, with 23% (GHQ-12) and 27% (GHQ-28) of nurses being classed as cases.

Community mental health nurses with poor stress outcomes (high GHQ-12 scores) are more likely to be divorced, widowed or separated, to smoke, and to feel insecure in their present job. These CMHNs are also more likely to have higher burnout scores on all subscales of the Maslach Burnout Inventory, have lower self-esteem, and make poor use of coping strategies that are available to them.

The long-term emotional effects of stress can be demonstrated for CMHNs in that one in two were experiencing high levels of the long-term effects of emotional exhaustion. One fifth of CMHNs felt that they did not relate well to their clients and just over one in ten CMHNs felt dissatisfied with their work and had no sense of personal achievement, as indicated by the MBI depersonalization and personal accomplishment subscales.

Conclusions

Overall, we conclude that CMHNs in Wales are experiencing high levels of stress. The GHQ-12 measure indicated that 35% of CMHNs had crossed a threshold of so-called psychiatric caseness. Measured against a normative sample of mental health workers, 51% of CMHNs were experiencing high levels of long-term emotional exhaustion. Twenty-four per cent were suffering from high levels of depersonalization burnout and not relating well to clients, whilst 14% were experiencing severe long-term feelings of a lack of personal accomplishment.

It appears from the findings of this study that a range of factors such as organizational pressures, and factors relating to working with patients, are important in determin-

ing stress levels. Addressing these factors may help to reduce levels of experienced stress and burnout. The authors plan to conduct further research into the area of stress management interventions, and their effectiveness in relation to mental health professionals.

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